CRANIOFACIAL PAIN & JOINT REHABILITATION
TMJ THERAPY INC.

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WELCOME TO TMJ THERAPY

Patient Name:_____ Email:_____
Address:_____City:_____State:_____Zip:_____
Home Phone #:_____Cell Phone #:_____
Birth Date:_____Age:_____Gender: Male Female Other:_____
Ethnicity/Race:_____Primary Language:_____
Social Security#:_____ Marital Status: Single Married Divorced Separated Widowed
Employed by:_____Occupation:_____
Emergency contact:_____Relationship to you:_____Phone:_____
Person Responsible for account payment: Self / Spouse / Parent / Other_____

Primary Medical Insurance:_____Member ID:_____
Insurance Phone #:_____Insurance Address:_____
Primary Subscribers name on Insurance Policy:_____Birth date:_____
Employed by:_____Social Security #:_____
Subscribers Phone #:_____Subscribers Address:_____
Patients relationship to the Insurance Primary Subscriber: Self / Spouse / Child / Other_____

Secondary Medical Insurance:_____Member ID:_____
Insurance Phone #:_____Insurance Address:_____
Subscribers Name/Address:_____Date of Birth:_____
Subscribers Phone #:_____Employer:_____
Patient relationship to the Insurance Subscriber: Self / Spouse / Child / Other_____

Who may we thank for referring you to our office?
Name:_____City:_____
(Please circle one) Google, Facebook, Our website, Instagram, Medical office, Dental office, Friend or Flyer

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company(ies) named above and assigned directly to TMJ Therapy, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by my insurance company. I authorize the use of my signature on all insurance company(ies) submissions. TMJ Therapy, Inc. may use my health care information and may disclose such information to the here-to-for named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is complete, or two years from the date signed below.

_____

Signature of patient/responsible party Date Relationship to patient

FINANCIAL POLICY

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency services, or any services performed without previous financial arrangements, must be paid for in cash at the time the services are performed.

All medical/dental services furnished are charged directly to you and **you are personally responsible for ALL payments. First X-Ray $425.00 and Consultation $149.00.** This office will help prepare insurance forms or assist in making collections from your insurance companies and will credit any such collections to your account or reimburse you as necessary 30 business days after treatment is final. However, this office cannot render services under the assumption that our charges will be paid by an insurance company. A service charge of 2% a month (24% annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for my care can only be extended for a period of up to three months from the date of this initial consultation.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five days of billing, if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof.

I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I further agree to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

I grant my permission to this company to call me at home or at work to discuss matters related to this form and account.

I have read the above conditions of treatment and payment and agree to their content.

_____

Signature of patient/responsible party Date Relationship to Patient

ACKNOWLEDGEMENT OF RIGHTS OF PRIVACY PRACTICES

A copy may be obtained of the Notice of Privacy Practices by TMJ Therapy, Inc., detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____

Signature of patient/responsible party Date Relationship to Patient

CONSENT FOR EXAM

I _____ give my consent for Dr. Carl McMillan and/or assistants for examinations/consultations and evaluations of my TMJ. I give my consent for TMJ Therapy, Inc. to download and review my prescription history.

_____

Signature of patient/responsible party Date Relationship to Patient

Release of Medical Records

I, the undersigned (patient or legally responsible party), authorize the release of a full report of examination, findings, diagnosis, treatment programs, etc., to any referring or treating physician. I additionally authorize the release of any medical information to my insurance companies or for legal documentation to process claims.

I assume financial responsibility for services rendered. I understand that I am responsible for all fees for treatment regardless of insurance coverage. It is understood that all X-rays, records, models and photographs taken remain the property of TMJ Therapy, Inc. Copies of these records may be obtained for an additional fee

_____

Signature of patient/responsible party Date Relationship to Patient

Epworth Sleepiness Scale – a standardized questionnaire

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation: **0** = would never doze; **1** = slight chance of dozing; **2** = moderate chance of dozing; **3** = high chance of dozing

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total score (add all scores above)	_____

History of Present Illness

Have you been medically diagnosed with (check all that apply):

___Yes ___No Sleep Apnea ___Yes ___No Migraine Headaches ___Yes ___No Tension Headaches

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center or sent home with an Oximeter test? ___Yes ___No

If yes, Sleep Center Name and Location:_____
Sleep Study/Home Oximeter Date: _____
Doctors Name who ordered test? _____

Allergies and Medications

List any medications which have caused an *allergic* reaction:

Y/N Antibiotics	Y/N Aspirin	Y/N Barbiturates
Y/N Codeine	Y/N Iodine	Y/N Latex
Y/N Local Anesthetics	Y/N Metals	Y/N Penicillin
Y/N Sleeping pills	Y/N Sulfa Drugs	Y/N Sleeping Pills

_____others

List any medications you are *currently* taking:

_____ _____ _____ _____

_____ _____ _____ _____

Medical History
Do have or experience:

Y/N Anemia
Y/N Arteriosclerosis
Y/N Asthma
Y/N Autoimmune Disorder
Y/N Bleeding easily
Y/N Chronic Fatigue
Y/N Currently Pregnancy
Y/N Diabetes
Y/N Dizziness
Y/N Dizziness
Y/N Emphysema
Y/N Epilepsy
Y/N Fibromyalgia
Y/N Frequent Sore Throat
Y/N Migraines
Y/N Memory Loss
Y/N Insomnia
Y/N Hay Fever
Y/N Osteoporosis
Y/N Jaw Joint Surgery
Y/N Morning dry mouth
Y/N High blood presure
Y/N Low blood pressure
Y/N Night time sweats
Y/N Osteoarthritis
Y/N Recent excessive weight gain
Y/N Rheumatic Fever
Y/N Chronic sinus Problems
Y/N Shortness of breath
Y/N Swollen stiff or painful joints
Y/N Heart disorder
Y/N Heart murmur
Y/N Heart pounding or irregular beat
Y/N Heart Pace Maker
Y/N Congestive heart failure
Y/N Hepatitis
Y/N Heart Burn or sour tastes
Y/N Injury to head neck or face
Y/N Current mouth or teeth Problems
Y/N Prior orthodontics
Y/N Thyroid problems
Y/N Tonsillectomy
Y/N Wisdom Teeth extraction
Y/N (GERD) Gastroesophageal Reflux disease
Y/N Do you need extra pillows to sleep at night
Y/N Difficulty concentrating
Y/N Muscle spasms

Family Medical History

Have any members of your family (blood kin) suffer from:

Y/N Anxiety	Y/N Blood Disorder	Y/N Bone Disorders
Y/N Cancer	Y/N Depression	Y/N Diabetes
Y/N Heart Disease	Y/N High Blood Pressure	Y/N Long Face Appearance
Y/N Lung Disease	Y/N Migraines/Headaches	Y/N Neuralgias/Neuropathy

Y/N Sleep Apnea/Snoring

Y/N Chronic Infections (HIV, Hepatitis, recurring pneumonia, ect.)

Y/N Neurodegenerative Diseases (Parkinson's, Alzheimer's, Lou Gehrig's, dementia, etc.)

Social History

1. Occupation: _____ Employer: _____
   a. Hours worked per week? _____

2. Are you Single / Married / Widowed / Divorced / Separated?
   a. How long ago were you widowed/divorced/separated? _____

3. Do you have *children* Y/N
   a. How many? _____ b. Age range? _____ c. How many still living w/ you? _____

4. Any recent *change* in lifestyle Y/N
   a. If yes, What? _____

5. Do you *exercise* regularly? Y/N or Occasionally

6. How often do you consume *alcohol*?
   ___Never ___Once a week ___Several days a week ___Daily ___Occasionally

7. Do you consume caffeine Y/N If Yes :
   ___ Once a week ___ Several days a week ___Daily ___Occasionally
   a. Type of caffeine? ____Coffee ___ Tea ___ Energy drinks __Energy pills ___Soda

8. Do you take any *sedatives* within 2-3 hours of bedtime Y/N If so how often?
   ___Once a week ___Several days a week ___Daily ___Occasionally

9. Do you *smoke* or *chew tobacco* Y/N
   a. ___Cigarettes ____Vapor ___Marijuana ___Chewing tobacco
   b. For how many years? _____9c. Amount per day? _____

Sleep Health/ Berlin Sleep Eval

Do you snore or have you been told you snore? Y/N

Has someone told you that you stop breathing or "hold your breath while you sleep? Y/N

When do you typically awake?_____

How long does it take for you to fall asleep? _____

How often do you wake up at night? _____ Why? _____

Where do you most often sleep? Bed, Couch, Chair, Floor, other_____

Do you gasp in your sleep or suddenly awake gasping for breath? Y/N

Do you have night time choking spells? Y/N

Do you feel rested when you wake? Y/N

Do you tire or fatigue easily throughout the day? Y/N

Do you get swelling in your ankles or feet Y/N

Usually, when is the last meal or snack of the day? _____

Do you use any medication, drugs, alcohol, supplements ect to help you sleep Y/N

If yes, what do you use_____

How often_____

Sleep Hygiene

Do you like your mattress Y/N

Do you like your pillow Y/N

Do you like your sheets and or blankets Y/N

Is your room at a comfortable temperature when you go to bed Y/N

Does your bedroom have a pleasant smell Y/N

Do you view any electronics in bed Y/N

Is your bedroom completely dark once you turn off the lights Y/N

Is your bedroom quiet at night time Y/N

Do you blow your nose and brush your teeth before bedtime Y/N

Do you have sources of dust above your bed?

I attest that the above information is accurate and comprehensive. I understand that an incorrect or incomplete health history that I have provided may cause an incomplete or incorrect diagnosis, which may cause delayed results or even incorrect treatment.

Patient Signature _____ Date:_____

TMJ Therapy, Inc Sleep Apnea Center
355 East 50 South
American Fork, UT 84003
www.tmjtherapyutah.com

Dr. Carl K McMillan
Dr. Ryan R. Hart
Phone: 801-756-0900
Fax: 801-756-7290

Name: _____ **Date:** _____

DOB: ____/____/_____

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, BUT could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

___mask leaks
___I was unable to get the mask to fit properly
___discomfort caused by the straps and headgear
___disturbed or interrupted sleep caused by the presence of the device
___noise from the device disturbing sleep and/or bed partner's/roommate sleep
___CPAP restricted movements during sleep
___CPAP does not seem to be effective
___pressure on the upper lip causing tooth related problems
___a latex allergy
___claustrophobic associations
___an unconscious need to remove the CPAP apparatus at night
___other: _____

Signature: _____ Date: _____

I, the undersigned physician, verify the above referenced patient has attempted to comply with AASM standards for sleep therapy by using continuous positive airway therapy as prescribed. To my satisfaction, the patient has attempted to comply with CPAP therapy but could not tolerate it. I would recommend other options for therapy, including oral appliance therapy for treatment of obstructive sleep apnea.

Name: _____

Office Name: _____

Office Phone: _____ Office Fax: _____

Signature: _____ Date: _____

Sleep Survey by the Bed Partner/Roommate

Patient name: _____ DOB: _____

Your name: _____ Todays date: _____

Your relationship to the patient: _____

We have found that the bed partners/roommate perspective is often more accurate when it comes to our patient's sleep health and habits. Please answer these questions about your bed partner/roommate as truthfully as you are able. If you don't know, write "IDK" for I don't know.

1. What time do they usually go to bed? _____
2. How long does it take for them to fall asleep? _____
3. When do they usually wake up? _____
4. Do they snore? _____Yes _____No
5. Do they gasp for breath while sleeping? _____Yes _____No
6. Do they stop breathing while sleeping? _____Yes _____No
7. Do they toss and turn at night? _____Yes _____No
8. Do they sweat excessively while asleep? _____Yes _____No
9. Do they struggle waking up in the morning? _____Yes _____No
10. How many times do they get up out of bed at night? _____
11. Do they struggle falling asleep? _____Yes _____No
12. How long does it take them to fall asleep? _____
13. Do their sleep habits affect your health and sleep? _____Yes _____No
    If YES, please explain:

    _____

    _____
14. What would you like to see improve in regards to your bed partners/roommates sleep and sleep habits?

    _____

    _____

Thank you for your help. We are excited to help improve the health and sleep of both you and your bed partner/roommate.